BlueCross BlueShield
Association
An Association of Independent
Blue Cross and Blue Shield Plans

Testimony

on

Provider Sponsored Organizations

before the

Subcommittee on Health and Environment
Committee on Commerce
U.S. House of Representatives

presented by

Mary Nell Lehnhard
Senior Vice President

March 19, 1997

Mr. Chairman, I am Mary Nell Lehnhard, the Senior Vice President for the Office of Policy and Representation of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present to the Commerce Committee the views of the 59 Blue Cross and Blue Shield Plans on the important topic of Provider Sponsored Organizations (PSOs).

BCBSA supports public policies that promote fair and vigorous competition because we believe this will expand the availability of affordable health care for all Americans. A healthy, competitive marketplace will best meet consumer demands for access to high quality health care -- and we believe Provider Sponsored Organizations (PSOs) should be part of this marketplace.

BCBSA does not oppose the formation of PSOs. In fact, many Blue Cross and Blue Shield Plans partner with PSOs to create, deliver and manage innovative health plans.

However, we are opposed to proposals that would exempt PSOs that contract with Medicare from the current requirement that all Medicare risk plans meet both federal standards for HMOs and be licensed by the state as meeting all the consumer protection laws in that state. Contrary to provider assertions, existing state licensure requirements for HMOs do not prevent the development of health plans that are

sponsored, controlled, and managed by providers. In fact, 14 percent of all licensed HMOs are provider controlled, i.e., PSOs.

Our testimony highlights our concerns that:

1) PSOs should be subject to current requirements that Medicare risk contractors meet both federal and state consumer protection rules.
2) Medicare beneficiaries should have the benefit of the protection of over **1000** state consumer protection laws that assure:
    - appropriate financial standards
    - adequate access to quality care
3) Unlicensed rural PSOs could jeopardize delivery systems in rural areas.

PSOs Should Meet Current Medicare Risk Contract Standards Regarding Federal and State Consumer Protections

Providers have asked Congress to exempt PSOs from current Medicare risk contractor standards requiring compliance with state consumer protection rules. Under these requirements, federal law provides a minimum set of consumer protection standards with which all Medicare risk contractors must comply. This provides a national "floor" for consumer protection. Medicare law also requires Medicare risk contractors to be licensed by the state and comply with state consumer protection rules so that beneficiaries have the benefit of the strongest protection standards available.

We believe that an exemption of PSOs from state licensure standards is unnecessary and presents unacceptable risks for Medicare beneficiaries as well as the Medicare program itself.

Medicare simply is not the p/ace to roadfesf unlicensed health plans. Medicare beneficiaries enrolled in PSOs should have the same protections as their Medicare neighbors enrolled in state licensed HMOs.

States that experimented in the past with separate standards for Medicaid HMOs met with disastrous results. For instance, Florida waived commercial HMO license rules for Medicaid HMOs in the early 1990s and consequently faced widespread abuses, including the provision of poor and possibly life threatening care. Florida has since required these entities to comply with all commercial enrollee rules.

Moreover, recent research indicates most PSOs are just emerging and are inexperienced in managing health care risk assumption. A 1996 survey by Ernst and Young on Integrated Delivery and Financial Systems indicated 71 percent of PSOs were less than three years old. Twenty percent of PSOs reported losing money last year, but most troubling of all-- nearly 40 percent of survey participants did not track the amount of revenue received and 20 percent did not know whether they were profitable or not. The business of managing risk requires a complex set of skills and

competencies; emerging PSOs need close monitoring at the local level

Medicare Beneficiaries Should Have the Benefit of State Consumer Protection Rules

Recent research by consumer attorney Carol Jimenez documents over 1000 state laws that currently protect consumers in prepaid health plans. These laws address a myriad of issues but are generally designed to assure two objectives:

1) The health plan is financially sound and ethically operated.

2) The consumer has adequate access to quality care from the health plan.

If Congress exempts PSOs from state licensure, Medicare beneficiaries enrolled in PSOs will not have access to the same level of protections as their Medicare neighbors enrolled in a state licensed Medicare HMO.

1) Consumer Protection: Financial Standards

The driving force behind consumers' enrolling in a health plan is their desire for security regarding future health care expenses as well as obtaining needed health care.

Financial standards (e.g. minimum net worth, investment rules, etc.) are the primary mechanism by which states assure consumers that a health plan will be capable of paying for its enrollees' health care needs currently and in the future. In today's

ultra-competitive health care market, such standards are necessary to assure that health plans have a financial cushion to protect against the implications of aggressively underpricing products to jump-start sales, loss of market share, unanticipated increases in utilization, or the enrollment of particularly high risk individuals.

PSOs claim they can be exempt from state requirements to hold minimum net worth standards in cash or cash equivalent assets because:

1. They have substantial assets (investments) in hospital plant and real estate; and
2. They employ the staff that provide care, and this staff's "sweat equity" -- the ability to work longer hours for no additional pay --will provide a cushion if a higher than predicted number of subscribers fall ill.

These arguments fail to adequately address the underlying reasons for the application of minimum net worth and investment standards to risk-bearing entities. These rules assure the existence of a financial cushion that PSOs -- like other health plans -- need to cover both internal and external costs:

- Internal Network Costs: PSOs, like other entities, must cover expenses incurred in providing services. Even if physician owners were willing to work longer hours at no cost, PSOs would still incur the expenses of nurses, physical therapists, and others that are not owners. In the case of hospitals, there is little room to

use “sweat equity.” Seventy-five percent of hospital expenses are labor related, e.g., nurses, nurses’ aides, cleaning and maintenance staff, etc. In addition, an unexpected level of patient illnesses would require cash payments for expensive pharmaceuticals, surgical kits and other hospital supplies.

- External Costs: PSOs must be able to pay for a subscriber’s emergency care that is obtained from hospitals that are not part of the PSO and tertiary care such as open heart surgery or cancer treatment that the PSO’s hospitals and physicians cannot provide.

In cases where a PSO fails to adequately estimate their patient care costs and lack a liquid --that is, cash equivalent --financial cushion, the PSO would be forced to borrow against or even sell its delivery assets. These buildings and equipment are the very items the PSO relies upon in order to deliver services.

States limit the investments that prepaid health plans can make in land, buildings or equipment because these assets, while valuable, cannot be readily converted into the cash needed to pay unexpected claims or to pay for out of network care.

State investment rules assure health plans can still pay claims even when plans incur unexpected underwriting losses. Otherwise, consumers could be left footing the bill when their health plan encounters cash flow problems or becomes insolvent.

The same investment standards must be applied to all risk bearing entities -- insurers, HMOs, PSOs, or whatever other organizations evolve, in order to provide consistent protection for consumers.

2) **Consumer Protection: State Standards for Access and Quality**

According to consumer attorney Carol Jimenez, there is nothing "magical" about Provider Sponsored Organizations that would warrant exemption from consumer protection rules. She states that PSOs are virtually indistinguishable from HMOs from a consumer's perspective.

Jimenez also dismisses PSO arguments that providers are less likely than HMOs to let financial pressures influence patient care. In fact, in a PSO there are likely to be fewer layers to give a financial cushion for the provider rendering care. Consequently, she argues that these entities must be subject to the same standards that states impose on local HMOs. Exemption from licensing standards for PSOs would mean beneficiaries in these PSOs would have separate *and unequal protections* from their neighbors who are enrolled in state licensed Medicare HMOs.

An exemption from state law would mean PSOs would not need to comply with state law, including:

- **Quality Assurance Laws:**

  States require health plans to develop and implement quality assurance plans, undergo external monitoring, and implement procedures for verifying the credentials of physicians and other providers. Other laws address utilization review.

- **Marketing and Enrollment Laws:**

  State laws prevent false and misleading advertising and eliminate practices designed to deny enrollment or continued enrollment to persons based on their health status.

- **Data Collection:**

  State laws require HMOs to track enrollee grievances, malpractice claims and report to the state. Other items required include patient outcome data and utilization data.

- **Access and Benefit Laws:**

  State laws regulate specialty care referrals, minimum time or distance that members should travel to obtain primary or other care as well as mandated benefits.

. **Grievance Procedures:**

All states require health plans to establish grievance procedures through which a member can appeal what he or she believes is an unjustified denial of coverage.

- **Conflicts of Interests**

State laws require HMOs to disclose any potential conflicts of interest and maintain a fidelity bond for those administering HMO funds.

Unlicensed Rural PSOs Could Jeopardize Rural Consumers' Access To Health Care.

PSO advocates argue that a PSO exemption from state law is necessary to expand access in rural areas. However, a recent report released by the Barents Group indicates that unlicensed PSOs could exacerbate current health care delivery problems in rural communities.

The report, "Are Unlicensed Plans Risky In Rural Communities?" concludes that the cumulative effects of the rural environment make financial standards even more critical for a rural PSO than for those in urban areas. Barents documents the unique challenges faced by rural health care delivery systems:

- **The prevalent use of out-of-area and out-of-network health care services by rural residents**

A review of rural research studies demonstrates that rural residents frequently travel outside of their local community for health care services. In fact, 60 to 80 percent of rural residents have traveled outside of their local area for hospitalization at some point in time. Rural residents receive treatment from non-local hospitals for numerous reasons, including emergency and tertiary care. Out-of-area services require cash payments by rural PSOs. This is one of the primary reasons states impose financial standards on risk bearing entities. PSO advocates argue that PSOs do not need to comply with state financial standards because "sweat equity" will allow providers to work long hours without increasing costs. But "sweat equity" cannot be used to pay for out-of-network services.

In addition, a high rate of out-of-area services severely constrains the ability of PSOs to manage the continuum of care — a managed care entity's most important cost control tool. As a result, rural PSOs may face a more volatile cost structure than those in urban or suburban areas.

- **A shortage of providers**

The shortage of health care providers in rural areas may make it difficult for PSOs to negotiate traditional risk-sharing arrangements with providers or influence provider practice patterns. Both risk-sharing arrangements and

utilization review and management are critical methods through which managed care entities stabilize their costs.

- **The potential for adverse selection**

  Rural PSOs face an accentuated risk for adverse selection because they operate in areas with small populations and a high rate of serious injuries. The challenges of rural health care suggest that PSOs would have difficulty attracting enough enrollees to spread their risks and to cover fixed administrative costs. A small population base limits the potential profit to be earned by a PSO even if costs are controlled. Yet the PSO remains at risk for substantial loss stemming from even a few enrollees with expensive illnesses.

- **Limited access to capital**

  Rural PSOs will need substantial capital to initiate operations. Adequate capital is necessary to finance the claims payments systems, medical management programs and other systems essential for creating an effective rural managed care organization. More importantly, adequate initial capitalization is imperative to pay professionals who are qualified to administer claims and financial systems.

The collective historical experience of HMOs indicates that adequate capital is one of the principal indicators in determining success. Yet providers are now asking for special exemptions from capital requirements for PSOs. Specifically, PSOs would

like to count hospital plant and equipment toward solvency standards. However, these assets --while valuable -- cannot readily be converted to cash to pay for unexpected health costs and prevent cash flow crises. Exemptions from state licensure (i.e. solvency and liquidity requirements) could result in undercapitalized PSOs endangering health care delivery assets in rural communities.

The financial failure of -- or even significant cash flow problems with -- a rural PSO could have devastating effects on local rural providers. Local providers could be left with large unpaid bills and community hospitals --which are already financially distressed -- could finally be forced to close their doors. The closure of a hospital would exacerbate current access problems as well as have a profound impact on employment and the overall local economy.

In a rural area where the loss of even one provider causes serious problems, the financial stability of a PSO is a great concern. Policymakers must ensure that the standards developed for PSOs reflect the unique characteristics of health care delivery in rural areas, especially providing for adequate financial cushions.

Conclusion

BCBSA remains opposed to provider initiatives to exempt PSOs from current Medicare risk contractor that standards require compliance with state licensure and

consumer protection rules. Under current Medicare rules, federal law provides a minimum set of consumer protection standards with which all Medicare risk contractors must comply. This provides a national “floor” for consumer protection. Medicare law also requires Medicare risk contractors to comply with state consumer protection rules so that beneficiaries have access to the strongest protection standards available. We believe Medicare beneficiaries deserve the protection of *both* federal and state consumer rules and that all Medicare risk contractors should compete on a level playing field.